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ABSTRACT

This paper reviews research on childhood depression and its relation to developmental processes, family functioning, academic performance, and peer relationships. The methodological strengths and weaknesses of the research are examined. A section on developmental perspectives looks at early childhood, school age children, and adolescence. Support is found for the importance of understanding developmental differences in the expression of childhood depression with respect to diagnosis and intervention. A review of studies conducted since 1980 reveals that, of currently depressed children, depression and psychological dysfunction among the parents are frequent. A review of longitudinal studies suggests that the remission or continuation of parental depression is concurrently and predictively linked to the severity of children's depression. The reviews found correlations between childhood depression and poor academic performance, dysfunctional family relationships, and diminished social competence. It is argued that clinicians working with depressed children should thoroughly examine developmental, family, academic, and social factors to implement maximally effective treatments. (49 references) (NB)

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CHILDHOOD DEPRESSION: A DEVELOPMENTAL PERSPECTIVE ON DISRUPTION OF FUNCTIONING

A Doctoral Research Paper

Presented to

the Faculty of the Rosemead School of Psychology

Biola University

In Partial Fulfillment

of the Requirements for the Degree

Doctor of Psychology

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by

Rebecca Lynne Snyder

May 1991

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CHILDHOOD DEPRESSION: A DEVELOPMENTAL PERSPECTIVE ON DISRUPTION OF FUNCTIONING

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Rebecca L. Snyder

Research is reviewed on childhood depression and its relation to developmental processes, family functioning, academic performance and peer relationships. The methodological strengths and weaknesses of the research are examined. Support is found for the importance of understanding developmental differences in the expression of childhood depression with respect to diagnosis and intervention. Childhood depression is found to be correlated with poor academic performance, dysfunctional family relationships and diminished social competency. The present paper argues that clinicians working with depressed children should thoroughly examine developmental, family, academic and social factors to implement maximally effective treatment.

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Childhood Depression: A Developmental Perspective on Disruption of Functioning

Introduction

Research in the area of childhood depressive disorders has burgeoned over the past twenty years. Prior to the 1970's the mainstream consensus in the mental health community held that children rarely experienced depression (Fleming & Offord, 1990). During the last decade the growing acceptance that depressive disorders can and do occur in childhood has initiated promising research for clinicians seeking to diagnose and treat depressed children. Researchers have recently moved beyond debating the existence or nonexistence of depressive disorders in children, and have instead begun to focus on childhood depression's epidemiology (Angold, 1988), the cognitive and social correlates of depression (Kennedy, Spence, & Hensley, 1988) and the risk factors for depression in children (Hammen, Burge, & Adrian, 1991). Most recently, measurement instruments designed specifically for the identification and diagnosis of depression in children are being validated (NIMH, 1989). These research efforts highlight the importance of understanding childhood depressive disorders for the professionals who work with children.

For many in the field, the acknowledgement that children do experience depression has been accompanied by an assumption that

childhood depression is essentially identical to adult depression. This assumption rests on a view of depression as a discrete "condition" or "disorder". While consistent with the disease model of psychopathology, this assumption overlooks the processes and mechanisms of development throughout childhood and into adulthood and instead focuses on the deviation depression represents from normal functioning. In doing so, the vital interweaving of a child's maturational process, biological propensities, early psychosocial experiences and current familial and social relationships are ignored.

The present paper explores these often-ignored issues and delineates the findings of current research regarding the relationship between depression and a child's family functioning, academic performance and peer relationships. These areas are key in understanding the context of development in which childhood depression occurs. Thus, this paper seeks to integrate the current clinical understanding of childhood depression as a disorder (American Psychiatric Association, 1987) with psychological research findings regarding the relational, cognitive and behavioral context in which depression occurs.

Frequently, the need to conduct empirically sound research leads to a narrowing of both what is studied and how research outcomes are understood. The current state of research in childhood depression provides such a narrow picture of the nature of depression in children. The present paper integrates the research on childhood depression to children's developmental maturation

processes, their familial and academic support systems and peer relationships as demonstrated in the research from 1980 to the present. It is asserted that such a broad perspective is necessary to reflect a conceptualization of the child as a whole person rather than as a diagnostic entity. It is also maintained that implications for intervention in the treatment of childhood depression are consistent with an integrated developmental perspective (Asarnow & Bates, 1988).

Methodological Issues

Selection Criteria and Organizational Preview

A review of the key empirical research in the area of childhood depression from 1980 to the present shows a virtual dearth of controlled experimental research. In fact, experimental research that examines the etiology of childhood depression has been characterized as "insufficient and insubstantial" (Kaslow, Rehm, & Siegel, 1984). The complexity of researching the reciprocal relationship of the effects of developmental features on psychopathology and conversely the effects of psychopathology on development in a meaningful and valid manner is undoubtedly challenging. In addition, many of the variables involved with childhood depression, such as family background and school performance, are difficult to experimentally manipulate, making correlational studies the likely choice of researchers in this area. Currently, research from a developmental perspective has maintained

a separate track from research focusing on the disorder of childhood depression.

There are several factors contributing to the lack of integrated research findings in childhood depression. First, the area of childhood depression is a relatively new one as an area of study. The years to develop organized, highly evolved areas of research are just now beginning to accumulate. It is expected that in the next ten years, a more complete body of literature will exist for childhood depression as it currently does for adult depression. Second, there are inherent difficulties in the assessment of depression in young children because of their limited ability to describe the emotions they are feeling. Even with adolescents, it has been found that parents and teachers frequently fail to notice depression, even when the young people themselves report severe depressive feelings during a personal psychiatric interview (Kashini, Burbach, & Rosenberg, 1988).

In spite of these limitations, there exists a body of robust correlational studies which assess childhood depression. While recognizing the methodological limitations of correlational research and the unique difficulties of assessing children, these studies, when examined as a whole, provide the foundation for conceptualizing the context of depressive disorders in childhood.

Methods of Investigation of Childhood Depression

Several serious methodological issues arise when evaluating the conclusions that can be drawn from correlational research. First, while correlational studies may reliably show that one cluster of

behavior tends to appear together with another cluster of behavior, this does not establish a causal relationship. Second, threats to internal validity, such as self-report biases, cannot be ruled out effectively through correlational research. However, when these factors are carefully evaluated on a study by study basis, correlational research can prove valuable for its predictive potential and its implications for diagnosis. For example, if poor academic performance is strongly positively correlated with depression in school age children (Fleming & Offord, 1990), then a child whose academic performance begins to drop dramatically may be a likely candidate for referral for psychological evaluation for depression.

The adequacy of samples used in the research demonstrates the considerable variation in the types and sizes of target populations. Generally, the sizes of samples throughout the research were adequate. In terms of the types of samples, most studies drew either from populations of psychiatrically hospitalized children or from populations of school children. Fleming and Offord (1990) pointed out that while psychiatric populations tend to include only the more severely depressed children, school samples tend to exclude school dropouts and those with poor attendance, possibly under representing children with more severe depressive disorders. Notably, in a study assessing the validity of DSM-III diagnoses of major depression in children, Beardslee, Klerman, Keller, Lavori, and Podorefsky (1985) included direct comparisons of both hospitalized and normal populations. Cole and Rehm (1986) also drew from more than one population when they compared the family interactions of

clinic/depressed, clinic/nondepressed and nonclinic groups of children. These two studies significantly broadened the generalizability of their results by using more than one sample population. Future research could be improved by doing this whenever possible.

The assumption of many of the investigators appeared to be that childhood depression can be meaningfully studied using mild to moderate self-reported depression in a normal child population (Altmann & Golib,1988; Kaslow, Rehm, & Siegel, 1984; Kennedy, Spence, & Hensley, 1988). However, these researchers have pointed out that the results found with normal children who are not severely depressed may not generalize to clinical populations. The replication of studies with a population of clinically depressed children would be useful in supporting or refuting the validity of such generalizations.

The quality of the research also varies according to the number and type of measures that are used to determine a subject's status as depressed or nondepressed. The most common method is the use of self-report, either through depressive symptoms checklists, such as the Children's Depression Inventory, or through a structured interview format, such as the Diagnostic Interview Schedule for Children. All of the studies reviewed provided information about the psychometric properties of the instruments used and about the methods of interviewer training. While these psychometric properties have been critiqued elsewhere (Costello, 1986), difficulties with reliability and validity of these measures also remain and are currently being addressed by a NIMH initiative to develop

more reliable and valid measures of childhood psychiatric disorders, including depression (NIMH, 1989).

Despite the relative difficulties with reliability and validity of these measures, research on childhood depression in the last ten years has begun to minimize the impact of these difficulties by using more than one measure within each study to identify depression. For example, Seagull and Weinshank (1984) utilized teacher and parent interviews, as well as children's self-report measures, in their study of low-achieving seventh-graders. Another study incorporated observations of behavior by trained experimenters with teacher, peer and self-report measures (Strauss, Forehand, Smith, & Frame, 1986). One added strength of using multiple measures to identify depressed children is that effects specific to the rater can be identified. For example, Strauss et al. (1986) identified that experimenter report was highly correlated with teacher report, but not with peer and self-report. Their findings opened up a new area of possible exploration to understand these differences meaningfully.

Some studies reviewed relied on only one means of gathering research data. For example, self-report questionnaires were the only type of measure in a study by Moyal (1977) on locus of control, self-esteem and depression in children. This researcher appropriately identified the benefit of adding to the use of self-report questionnaires the study, by including clinical interviews in future research. In addition, this particular study used the children's regular classroom teachers to administer these questionnaires, introducing demand characteristics unique to the teacher-pupil

relationship. In general, support is warranted for the use of a combination of verbal, written, behavioral observation and interpersonal judgment to adequately cover important aspects in evaluating depression in children.

The study conducted by Altmann and Gotlib (1988) of the social behavior of depressed children is particularly commendable for its breadth and applicability. Children in this study were selected according to their scores on both the Children's Depression Inventory and the Peer Nomination Inventory of Depression. The behavioral observation portion of the study was carefully controlled using coders who were blind to the experiment's hypotheses and to the children's group assignments. Second observers were also used which independently coded the behavior of 20% of the children at random and high interrater reliability of the observers was also established. These efforts to control for possible confounding aspects of the design allowed for more confident interpretations of the experimenters' conclusions that depressed children made more inappropriate overtures for social contact than did the nondepressed children, spent more time alone and engaged in a higher frequency of negative interactions with their peers.

Another methodological concern relating to the generalizability of the research on childhood depression is the preponderance of research which relies on only one time sampling to assess the presence or absence of depression. Few of the studies used an experimental design which included performance on depression measures obtained on more than one occasion. Certainly, it would be

valuable to have more longitudinal studies of children who were identified as depressed during an initial study. Implications concerning the transitory versus long term nature of depression could then be drawn more confidently. Longitudinal research, while costly and time consuming, could also yield the possibility of making more powerful inferences concerning causation through the use of analytic techniques such as path-analysis and structural modeling (Quay & Werry, 1979).

Despite design flaws, the adequacy of the statistical measures used for research reviewed was quite good. Multivariate analysis of variance was employed as the primary statistical tool for analysis to determine overall group differences. Factors such as the child's age, race and IQ, and mother's age, race and SES were consistently included in these analyses. Between groups comparisons of categorical data (e.g. gender) were made using chi-square analyses. As might be expected, more robust statistical outcomes were possible in studies with greater sample size.

In summary, methodological critique of the research reviewed indicates that etiology related to childhood depression cannot yet be inferred because of the largely correlational nature of the data. However, the consistent findings that relate to developmental differences, academic performance, family functioning and peer relationships can be considered useful for determining the direction of future research. Issues surrounding the internal validity of the research could be better resolved through future experimental research utilizing control groups. In terms of external validity, each

study should be examined individually, taking into account the population drawn from for subjects and the particular situational factors. The generalization of results from clinical to normal populations should especially be examined in future research.

Thus far, it has been identified that the area of childhood depression is one of growing interest for researchers and clinicians. Recent research has turned from the assumption that childhood depression is identical to adult depression, and instead has begun to explore the developmental processes operating throughout the lifespan that impact the expression and experience of depression. The outline of this developmental process, along with the contextual variables of childhood depression, including family functioning, academic performance and peer relationships will now be reviewed.

Developmental Perspectives

The task of eliciting a response from a child who may only recognize distress, and be unable to define it, much less seek help on that account, makes depression especially difficult to diagnosis in young children. Beardslee et al. (1985) supported the view that regardless of the difficulties involved in diagnosing childhood depression, it is no longer a question of whether depression can occur in childhood or not. Rather, it is how the cognitive and affective limitations at various stages of development modify the experience and expression of emotions in general. It seems likely that significantly more depressed children exist than are now recognized and the rate may be increasing (Ney, Colbert, Newman, & Young, 1986).

Early Childhood

The increasing numbers of depressed children make it imperative that professionals working to identify childhood depression become aware that depressive symptoms may vary depending on the developmental stage of the child. It is clear from clinical descriptions since the turn of the century that sensory and social deprivation in the first year of life creates a syndrome which resembles the behavioral aspects of an adult depression (Friedman, 1973). In his now famous studies, Spitz (1946) described "anaclitic depression" in the second half of the first year of life, describing these infants as listless, immobile, unresponsive, and as having sleep and eating difficulties.

Depression during infancy is most likely a basic psychological-biological reaction to deprivation. During infancy, the child obviously lacks the ability to verbally express depressive affect. Depression may be manifested in the infant's general mood and behavior. The infant may cry frequently, and for long periods of time, without appearing to derive comfort from any adult response (Izard, Huebner, Risser, McGinnis, & Dougherty, 1980). Lack of appetite and slow growth are also possible physical signals of depression during infancy. Although fear, shame and guilt play a complex role in adult depression, the experience of these emotions may be relatively more dependent on the attainment of higher cognitive skills and on a more stable sense of self than is possible in infancy (Fisher & Jones, 1980).

By early childhood, verbal expression of feelings is possible. The normal emotional ability of playful exuberance and laughter to fearful

crying makes discerning clinical depression more complicated. The cognitive limitations of this period prevent the child from understanding future time, anticipating long term consequences of behavior or even of maintaining mood changes over time (Altmann & Gotlib, 1988). A young child's mood appears to be primarily tied to external events, and thus occasions of depressive feelings may be more fleeting (Cantwell & Carlson, 1983). If the investigator does not observe the actual disturbing event, the emotion may not be detected. Cantwell and Carlson (1983) suggested that denial, grandiosity and involvement in fantasy may protect the child from high-level awareness of negative emotions.

Erikson (1963) saw this as the stage of dealing with autonomy versus doubt. Behaviorally, depression may be observed through excessive problems with separation from the primary caregiver. Depressed children at this stage might display excessive clinging behavior, or appear inhibited and withdrawn (Fisher, 1980). Alternately, some researchers have found that maltreated children may appear "overly cheerful" when taken from the home where they are being maltreated, only to slip into withdrawal after several hours or days in the new environment (Kaufman, 1991).

Lack of interest and the facial display of sadness are also consistently mentioned in the 2-5-year-old group as symptoms of depression (Kashini, Orvashel, Rosenberg, & Reid, 1989). A frequent response to pain and frustration according to these researchers is anger and tantruming, followed by sadness and withdrawal. In naturalistic home observations of children in this age group, Kashini

et al. (1989) observed what appeared to be a pattern of cyclic anger and attempts at active coping with the increase in social demands and a widening available physical environment. The pervasive push for growth that children are experiencing during this period, coupled with their attempts to gain self-control and autonomy make this period a crucial juncture in development.

School Age Children

Even school-age children may not be developmentally capable of recognizing the state of unsustained unhappiness as depression (Costello, 1986). This limitation is supported by the finding that children under ten reported states of internal feeling with little consistency when re-interviewed over a two week period (Beardslee et al., 1985). Moreover, children may be heavily influenced by the context in which they are asked about their feelings during an interview (Fisher, 1980). The rich fantasy life of the young child makes it likely that verbalizations will center around the affect of favorite television characters or that they may occur spontaneously during play with dolls or toy animals (Lasko, 1986).

In the 6-9-year old groups the pattern of emotional expression undergoes further refining. For the first time in the developmental process, researchers suggest that a shame component can be identified by researchers and is self-reported by children (Fleming & Offord, 1990). The shame component is more salient in children's reports of low self-esteem, excessive self-criticism, and masochistic behavior. The important developmental changes during this period such as the achievement of the Piagetian stage of operational

cognitive development, as well as entry into formal school settings promote the opportunity for the child to be observed and to receive feedback from a broader social world. Erikson (1963) viewed the psychological tasks of 6-9-year old children as establishing a secure sense of industry versus inferiority. These theoretical factors coincide with the increased prevalence of shame and low self-worth in depressed children of this age reported in the literature.

The child during the 9-11-years of age is increasingly able to internalize parental and societal standards of behavior. Children progress into what Piaget (1963) described as the concrete operational stage of cognitive development. In this stage of development, children's thinking is becoming more independent from external events and verbalization is steadily improving as a resource for problem solving and expression of feeling (Kashini et al., 1989). Costello (1986) reported that depressive disorders that involve an awareness of violations of internal standards are more likely to be found in this older group. This researcher also suggested that the combined symptom picture of anger and acting out with subsequent sadness and withdrawal is seen in this age group as it is with 6-9-year olds.

Adolescence

When reaching latency and particularly adolescence, the young person's cognitive maturity level has developed to increase his or her ability to understand reality in a way that allows for the expression of visible signs and symptoms of depression. The young person's growth and maturation are coupled with increasing tendencies

toward verbalizations and overt moods, making the clinical picture appear more like adult depression. This also allows the structured interview to become a more viable research tool for accurate diagnosis. Prior to latency and adolescence, reliance solely on formal interviews to gain a window into the child's affective experience are of limited value and may miss the behavioral, nonverbal depressive symptoms.

Berger (1984) reviewed the existing literature on adolescent depression and concurred that on the basis of structured interviews with junior high and high school children, depressed and nondepressed youth can now reliably be distinguished. McGee, Anderson, Williams, and Silva (1986) utilized a structured interview focusing on the youth's present affective state and behavior to diagnose depression in latency aged children with good results. In this study, they focused on the cognitive correlates of depressive symptoms, including low self-esteem and self-perception of scholastic ability. Since self-esteem and self-perceptions in general involve developmentally mature cognitive skills, it is unlikely these could have been explored in an interview format with children of a younger age.

In addition to structured interviews, depression scale instruments have proven useful for latency aged children and adolescents. Researchers at Johns Hopkins University School of Medicine have recently completed extensive norming on a 38-item symptom checklist based upon DSM-III criteria for depression (Joshi, Capozzoli, & Coyle, 1990). These investigators suggested

that an older child's increasing ability to use language to describe his or her affective experiences allows a clear-cut symptom checklist to become a viable tool for assessment. Other researchers, however, have cautioned against using only the self-report of young adolescents. For example, Kazdin, Colbus, & Rodgers (1986) studied the relations between performance on standardized depression scales of childhood depression and the diagnosis of depressive disorder. Youth and parents both completed four standardized depression scales plus measures designed to assess associated features including hopelessness, self-esteem, and internalizing symptoms. Overall, scores on each of the depression measures, whether completed by youth or parents, were significantly higher for youth with a diagnosis of depression. However, for each measure, parents' ratings of depression were consistently higher than the ratings by the youth themselves. This suggests that parents may be more likely to report symptoms of depression than young adolescents are either less able or less willing to endorse.

Interestingly, adolescence is the first phase of development that reveals findings of a higher prevalence of depressive disorder in girls than in boys (Kashini, Sherman, Parker, & Reid, 1989). The frequency of depression in pre-puberty is roughly equal for boys and girls and only begins to approximate the ratio found in adult men and women around age 16 (Kashini et al., 1989). Although the reasons for the sex differences in frequency of depression and depressive symptoms are not clearly understood and go beyond the scope of this paper, it is helpful information in support of the assertion that

development influences the expression and experience of depression.

In summary, childhood depression may manifest itself differently depending on the developmental age of the child. During infancy the child lacks the verbal fluency to express depressive affect. Depression is manifested instead in the infant's general mood and behavior. By early childhood, verbal expression of feelings is possible. Nevertheless, the concrete nature of young children's thinking and their immature reality testing may restrict their expression of depression to play and other general behavior. Advancing age brings more mature reality testing, growth and maturation, and is coupled with increasing tendencies toward verbalization and overt moods. The older child's development toward adult-like expression of emotional states increases the likelihood that depressive symptoms will be recognized.

Childhood Depression and Disruption of Functioning

Family Functioning

Research involving the etiology of depression in children has frequently centered around the family systems of such children. This line of research is highly practical for three reasons. First, evidence of any dysfunctional patterns that exist in families with depressed children can aid in the predictive identification of at-risk children, so that preventive interventions can be made. Second, intervention can be designed to introduce change into presently dysfunctional families, benefiting the child and the family as a whole. Third,

clinicians can utilize knowledge about a child's family to implement a treatment program that will involve both the home and the school systems. Consistent and strong evidence points increasingly to the association between parental depression and depression in children. Beardslee, Bemporad, Keller, and Klerman (1983) reviewed the culmination of offspring research, as well as family studies of children in treatment for affective and other disorders. Most of this research has been completed for maternal unipolar depression. Although the consensus of these researchers is that a depressed parent will more likely produce depressed offspring, the nature and mechanisms of the relationship between paternal and child psychopathology are still tentative.

Billings and Moos (1985) pointed out that the depressed parents' level of functioning or remission are concurrently and predictively linked to their children's own levels of depression. These investigators examined in a 1-year follow-up parents who were previously identified as depressed and divided them into two groups: (a) parents who were previously depressed, but whose symptoms are in remission; or (b) parents with continuation of depressive symptoms. Although remitted parents and their family social environments showed improvement, their children were still functioning more poorly than children of socio-demographically matched control families. Billings and Moos (1985) also found the severity of family stress to be related to the degree of the children's dysfunction, with lower levels of family cohesion and interpersonal support found to be associated with impaired functioning. Hammen,

Burge, and Adrian (1991) found results consistent with Billings and Moos (1985) in their study on the timing of mother and child depression in a longitudinal study of children at risk. Hammen et al. (1991) expanded the scope of previous research in a 3-year longitudinal study of unipolar, bipolar and nondepressed comparison women and their 8 to 16-year-old offspring. In a well designed study they found a significant temporal association between mother and child depressive episodes. In fact, the majority of children who experienced a major depressive episode did so in close proximity to maternal depression. Only one of 11 episodes of major depression in the children were unrelated in time to their mother's depression. Furthermore, the children's stressful life events and maternal disorder, and the interaction of the two significantly predicted children's changes in depression.

Interestingly, children who were exposed to high stress but with nonsymptomatic mothers were significantly less depressed following the cessation of the stressors than those who also had symptomatic mothers. One possible explanation for this has to do with the effects of maternal depression on the mother's ability to provide appropriate support and attention to the child. When the child experiences stressful circumstances, he or she is especially likely to need such support to buffer the effects of the stressors. Without such support, the child is more susceptible to depression themselves. Certainly, maternal depression is one particularly severe form of stress for children, contributing to the child's overall level of stress. Further studies to pinpoint the effects of parental depression and high family

stress at various points in the course of children's development would be helpful. Such research might assist in answering how a 1-year-old is affected differently than a 13-year-old by their parent's depression.

Kashani, Husain, and Shekim (1981) noted that depressed mothers have more conflicts with their children and have greater difficulty showing affection, expressing affect, and communicating with their children than do normal mothers. Cole and Rehm (1986) hypothesized that parents of depressed children reward their children less and punish them more than parents of nondepressed children. Extending their theory, Cole and Rehm (1986) also showed that depressed children rewarded themselves less and punished themselves more than did nondepressed children. In addition, parents of depressed children set higher standards for their children than did parents of nondepressed children, and depressed children set higher standards for themselves than did nondepressed children. While much of their research focused on mothers, it was found that fathers of depressed children withheld praise for only high levels of achievement. In addition, for both groups, fathers' rates of positive expressions were two-thirds the rates of the mothers' responses, suggesting that additional research with fathers is desperately needed.

Cole and Rehm (1986) suggest that depressed parents maintain their child's depressed behavior by setting high standards and by giving less praise and more punishing responses. Children then internalize this pattern of behavior by rewarding themselves less and

punishing themselves more. The mutual interplay of parent and child influences can be seen throughout this process. Minuchin (1985) suggested that it is likely that the child's temperament or behavioral style may interact with the disciplinary style of the parent to create a feedback loop in their interaction and thus perpetuate a differential behavioral response to stress. A child with a tendency to withdraw under stress may invite parental (or teacher) neglect, enhancing the likelihood of the emergence of a pattern of child withdrawal and parental neglect. It may be difficult to determine the origins of such a feedback loop, i.e. whether the child has developed a behavioral style that fits his or her temperament or a style that has been modeled by the parent or whether the behavioral style parallels the child's temperamental characteristics and elicits a particular parental response.

Research has given consistent support to the idea that separation from parents may be one frequent factor in the development of depression. This separation may be due to divorce, illness, death or extended job-related separation (Bohrnstedt & Fisher, 1986). There is also some indication that the quality of family interaction prior to and subsequent to separation by death of a family member or divorce can determine the ultimate effect on a child. Higher levels of family cohesion and interpersonal support were associated with lower frequencies of major depression (Garrison, Jackson, Marsteller, McKeown & Addy, 1990). While separation is possibly one factor related to childhood depression, certainly many children become

depressed without experiencing a loss or separation.

In another direction of research, depressed children and their mothers were compared to conduct disorder children and their mothers (Field, Sandberg, Goldstein, Garcia, Vega-Lahr, Porter, & Dowling, 1987). Similar psychosocial risk factors have been reported for both groups of children. Among these are low socioeconomic status, loss or absence of parent(s), family dysfunction and disturbed relationships, inadequate childrearing practices and parental psychopathology (Altmann & Gotlib, 1988). Children exhibiting conduct disorder or depression also appear to manifest similar intrapsychic processes, including low self-esteem, general unhappiness and external locus of control (Moyal,1977). Parents of children with conduct disorder and childhood depression have been noted to have similar rejecting parenting styles. However, the rejecting attitude by parents of depressed children is more often expressed by affective withdrawal, lack of warmth or nurturance and neglect. This contrasts with the angry outbursts of hostility or harsh discipline dispensed unevenly, behavior which sometimes characterizes the rejecting attitude of parents of children with conduct disorder in these studies.

Other results from the study by Field et al., (1987) indicated that on the self-concept scale the depressed children scored significantly below conduct disorder children and normals. On the locus of control measure the depressed children reported a more external locus of control than the normal or the conduct disordered children. The depressed children also engaged in the least amount of fantasy

play. In contrast, the normal children sought instruction from their mothers and were more involved with their mothers than were the other children. The mothers of the normal children talked, smiled/laughed and received a more positive affect rating than the mothers of depressed children. They also showed more contingency responsivity than the mothers of both the depressed and conduct disorder children. Depressed children spent more time talking to themselves than the normal children during the solitary free play sessions. They also expressed their incompetence more and completed the assigned tasks less often and were less involved in freeplay with their mothers.

Lefkowitz, Tesiny, and Gordon (1980) utilized the medical records and backgrounds of children with diagnoses of depression from a residential facility for emotionally and physically abused children. These records indicated that the majority of these children had depressed parents, unrestored losses and frequent changes in environment. Many of the children had parents who were abusing alcohol or drugs. Histories of excessive punishment, physical neglect, early separation and rejection were common. The most common symptoms of depression in these children were low self-esteem, sadness, behavioral disturbances, irritability, somatic complaints and aggressive behavior.

In a study by Kaufman (1991), the researcher described dramatically the maltreatment experiences of a 8-year-old boy who attended a 1-week therapy camp, and his difficulty in making attachments with the counselors at the camp because of his self-

reported lack of trust that an adult could care for him. Unfortunately, this boy was just one of 56 7-12-year-old maltreated children in this study, many of who reported similar difficulties with trust and attachment. Of the 56 children in the study, 25% met the full criterion for major depression, and a larger percentage met the criterion for dysthymia. The present study also included rankings of the severity of maltreatment experiences and found a relationship between the severity of maltreatment and the severity of depressive symptomatology. Notably, children with more identified positive supports outside of their families were less likely to be depressed than the other maltreated children in the study.

Academic Functioning

Often it is the classroom behavior of depressed children that accounts for referral by a teacher for psychological evaluation. It is logical that a child's behavior in the classroom, where structured interactions and increased social demands exist, is a likely place for depressive symptomatology to cause notice. Given that behavioral correlates of childhood depression include irritable mood, diminished interest or pleasure in activities and psychomotor agitation or retardation and a diminished ability to think or concentrate (American Psychiatric Association, 1987), it is not surprising that a depressed child's ability to perform adequately in the classroom is frequently and significantly impaired.

A synthesis of the research provides evidence supporting a negative relationship between childhood depression and academic performance. Cantwell and Carlson (1983) suggested that childhood

depression, independent of learning disabilities, are a common condition in children who are doing poorly in school. In more specific research, investigators have found an inverse relationship between severity of depressive symptoms on the one hand and standardized test scores and teacher ratings of performance on the other (Colbert, Newman, Ney, & Young, 1982). Moreover, the depressed children of school age studied by Colbert and associates tended to exhibit significantly lower motivation for sustained efforts at achievement. Low motivation as a characteristic of depression has clear negative implications for successful school performance, which requires a premium of a child's ability to concentrate and sustain effort.

A frequently cited study by Kaslow, Rehm, and Siegel (1984) found significant differences in performance on some subscales of the WISC-R (block design, coding and digit span) among children with depressed mood. These researchers examined a child's scores on a standard self-report measure of depression and found a negative correlation with performance on specific WISC-R subtests. That is, the more depressed the child, the more impaired their performance on block design, coding and digit span. The investigators also found that depressed children's performance in completing a pencil and paper "trailmaking" task, which requires attention and concentration, was significantly impaired in comparison to nondepressed children in the same study.

In related research, depressed children (ages 6-11) were found to have deficits when tested on problem-solving tasks taken from

academic materials standard for the children's various grade levels (Kaslow, Tanenbaum, Abramson, Peterson, & Seligman, 1983). These deficits in the depressed children's ability to successfully complete age-appropriate problem-solving tasks are consistent with the research by Costello (1986) which identified frustration and subsequent withdrawal from social demands in children of similar age. Kaslow and associates attributed these deficits in problem-solving ability to negative self-evaluation and low self-concept. This attribution coincides appropriately with developmental data about children's cognitive development in these ages. Asarnow and Bates (1988) found similarly that depressed children who were psychiatric inpatients showed significantly more hopelessness about their ability to perform academically.

McGee, Anderson, Williams, & Silva (1986) further investigated the hypothesis that depressive symptomatology in children is associated with impairment on cognitive tasks. Their study differed from that of Kaslow et al. (1983) by suggesting that while depression as a broad classification was not significantly correlated to performance on specific subscales of the WISC-R, measures of self-reported inattention were associated with poor performance. Thus, it is possible that children's self-report of diminished attention is a specific component of depression that impairs performance for some depressed children. The findings of this study stress the importance of evaluating for possible distortion of self-perceptions regarding ability and performance, rather than solely with actual task performance.

Further support for the idea that depressed children are similar to depressed adults in their attributional style comes from the work of Bodiford, Eisenstadt, Johnson, and Bradlyn (1988). In a study using multiple measures of depression including self-report, parent-report and behavioral observation, depressed children from a normal population were found to attribute bad outcomes to internal, stable and global factors. These children were more likely to attribute good outcomes to external, unstable and specific factors. In other words, these children tended to blame themselves for negative events and failed to accept credit for positive events. This pattern of self-blaming might be hypothesized to hinder the child's ability to persevere through difficult academic tasks and to strive beyond failure experiences.

Thus, learning impairments may be a result of the combination of poor concentration and negative self-perceptions of ability that the depressed child frequently possesses. If the depressive symptoms interfere with concentration, a child cannot comprehend as well, and the child's already poor self-perception is reinforced by a consequently poor performance. As the hypothetical downward spiral continues, the child likely receives negative feedback from a teacher for his or her performance, and then goes home to receive the same negative reception for his or her poor report cards.

The question of whether specifically diagnosed learning disabilities puts children at greater risk for depression has also been studied. Emotional problems in general have been found in as many as 76% of learning disabled children (Livingston, 1985). Low self-

esteem, one common characteristic of depression, is said to be prevalent among learning disabled children according to researchers (Kennedy, Spence, and Hensley, 1988). These researchers found that the diagnosis of major depression was more frequent in children with previously diagnosed learning disabilities than in controls or (to establish a more specific relationship) in children with other psychiatric difficulties. McGee et al. (1986) also found significantly more pre-existing reading and arithmetic difficulties among children with depression than among those admitted with other diagnoses in a series of 100 children admitted to a community mental health center.

Further studies by Ney, Colbert, Newman, and Young (1986) showed that of the 80 depressed children receiving specialized classroom instruction for diagnosed learning disabilities, a significant percentage were likely to demonstrate irritable mood and aggressive acting out rather than withdrawn, dysphoric mood. These researchers found a significant positive correlation in depressed children between aggressive behaviors and learning disabilities. They suggested that aggressive behaviors in learning disabled children should be evaluated carefully as symptoms of depression.

It is important for clinicians to be able to distinguish between depressed children who consequently have learning disabilities and those who have learning disabilities and are subsequently depressed. Findings supporting the relationship between poor school performance as a part of the clinical picture for many depressed children has highlighted this question in respect to primary and

secondary diagnoses of depression and learning disabilities. As the literature reviewed indicates, an interaction exists between learning disabilities and depression in school aged children. Learning disabilities may contribute to depression, and depression may contribute to learning disabilities and subsequent school difficulties. However, without further experimental research, a relationship of causation in either direction cannot yet be confidently identified.

Colbert et al., (1982) suggested that treatment of children's depression will not automatically improve their achievement in the classroom. Due to the nature of school-related learning, difficulties in early learning have a continued impact on subsequent learning, regardless of the reason for the initial difficulties. Research by Seagull and Weinshank (1984) showed that remedial teaching may have a non-specific positive effect of improving the child's learning by lessening his or her depression through sympathetic, one-to-one adult attention.

While a clear directional relationship between learning disabilities and depression cannot be ascertained by current research, several factors suggest that the diagnosis of learning disability is more likely to be the one of choice by teachers (DiCocco, 1986). Teachers may more readily detect a learning disability than depression because the former seems easier to deal with and does not imply adult neglect. Teachers are also more likely to diagnose a learning disability. In part, this is because they are better trained to detect learning disabilities. Further, a diagnosis of depression may require referring

the child to a less readily available service, such as psychotherapy, while remedial teaching is typically within easy availability.

In summary, the literature has provided consistent evidence supporting a negative relationship between childhood depression and academic performance. Some researchers have suggested that specific impairments can be found on the WICS-R, particularly those involving attention and concentration (Kaslow et al., 1984). Further confirming research in this area would be informative. Research involving the self-attributional processes in children shows that depressed school age children are more likely to attribute good outcomes to external factors and to internalize blame for negative events in their lives (Bodiford et al., 1988). Learning disabilities have also been correlated with childhood depression, although an interactional relationship is the one most likely posited by researchers (Ney et al., 1986).

Peer Relationships

Within the framework of developmental differences in the behavioral expression and affective experience of depression, research has located several factors that are consistently linked with childhood depression, including family functioning and academic performance (Cantwell & Carlson, 1983). Another key factor is that of a depressive child's difficulty in maintaining supportive, close peer relationships. In general, it has been found that children reporting depressed symptoms exhibit marked deficits in social functioning when compared to their nondepressed counterparts. For example, Jacobsen, Lahey, and Strauss (1983), in their often cited study with

school attending children, found that for both boys and girls, unpopularity with peers as measured by self-report and peer nomination was significantly correlated with high scores on three depression scales.

In a recent study by Kennedy, Spence, and Hensley (1989), 43 primary school children who scored in the clinical range of the Children's Depression Inventory were compared with a control group of 43 children to assess the relationship between childhood depression and social competence. Rather than seeking evidence to clarify the direction of causality between these two variables, the investigators sought to study in detail the nature of the interpersonal difficulties experienced by children who report high levels of depressive symptoms. To assess social competence, Kennedy and his associates used two measures of peer popularity, self-reported social skill performance and tendency toward assertive, submissive and aggressive behavior.

The results indicated that children who report high levels of depressive symptomatology are more likely to report tendencies toward lower assertion and greater submissiveness than their nondepressed peers. Children who reported being depressed received fewer positive nominations from their peers and far more negative votes than their nondepressed counterparts. The majority of children in the depressed group (80%) were categorized as isolated or rejected by their peers. This finding that depressed children tended to be overlooked and neglected by peers, and that a surprisingly high percentage (50%) were reported to be actively

disliked is disturbing. Kennedy and his associates suggested that depressed children are likely caught in a vicious cycle; their social skill deficits make them more likely to be the object of social isolation and rejection, increasing the child's stressors and depression, which in turn reinforces the child's isolation and rejection and so on.

A study by Altmann and Gotlib (1988), utilized observation of 20 depressed and 20 nondepressed children in free play during their recess period at school and subsequent individual sessions about their self-perceptions regarding social functioning. The results obtained were consistent with those of Kennedy et al. (1989). Altmann and Gotlib found that depressed children tended to spend much more time alone and less time interacting with others. Moreover, when they were interacting with their peers, depressed children demonstrated more behaviors that were deemed negative, such as complaining, "whining" and crying. Consistent with these direct observations of depressed children's behavior, in individual interviews the depressed children reported more negative self-perceptions; both globally, in terms of their worth as a person, and specifically, in terms of their social competence.

In another investigation, Seagull and Weinshank (1984) studied the social competence of junior high students deemed to be depressed using three depression checklists, parent and teacher reports and behavioral observation. Students identified as depressed were rated by parents and teachers as more task avoidant, introverted and socially isolated. Clinicians observing the depressed

youth confirmed that behaviorally these students smiled and laughed less, had less animated voice quality, were more lethargic and had more flat and sad facial expressions than nondepressed students. While this study did not include the junior high student's self-perceptions of social competence, it would be valuable to replicate these findings with older students and include such self-perceptions to expand the research generalizability.

A strong negative correlation has been found between depression and self-esteem (Seagull & Weinshank, 1984). Students in this study were rated by teachers as more task avoidant and anxious. They also appeared to the teachers as relatively unresponsive to praise or blame. Like adults, many of these depressed children reported vegetative symptoms and somatic complaints, including headaches, abdominal pains and disturbed sleep patterns. Consistent with this, they reported more visits to the school nurse and more absences from school for illness.

In summary, depressed children appear to have more social difficulties than do nondepressed children. Initiating and maintaining supportive, close peer relationships appears to be one of the most difficult aspects of daily life for depressed children. Particularly during school age and into adolescence, where the peer group serves a vital function in transitioning toward familial independence in adulthood, the development of depressed children may be compromised. Depressed children were found to be both more aggressive and negative with peers (Altmann & Gotlib, 1988) and less assertive and isolative (Kennedy et al., 1989). They were

also found to whine and complain more than nondepressed children (Estrada, Arsenio, Hess, & Holloway, 1987).

Implications for Intervention

It is growing clearer that efforts to effect changes in childhood problems such as depression are likely to be ineffective and at best short-lived without a thorough understanding of the developmental, family, school and social factors related to the problem. Some theorists purport that to the degree that psychotherapy, family and school operate as separate worlds, they adversely impact the well-being of children (Tucker & Tyson, 1976). Such theorists point out that all too frequently there is little communication between the treatment providers, families, and the school. Unfortunately, this approach often misses valuable information and insight into the underlying factors of a child's depression. Frequent and in-depth communication between the child's family, school and clinician provides the best basis for implementing a sound, broad-reaching treatment plan.

When a child presents with a depressive disorder, the adults involved must take action for the child's benefit. When two sets of authority are involved, such as the school and the parents, there is potential for conflict between these systems that will be detrimental to the child. The well-informed clinician can frequently act as a mediator and assist in planning interventions that maximally utilize the best capabilities of the two systems (Stone & Peeks, 1986).

Concluding Comments

The theories and research reviewed in this paper were selectively chosen to highlight the importance of understanding the critical issues surrounding childhood depression. Acknowledgment from the mental health community that children experience depression has led the way to new and exciting research on the interaction of children's developmental process and their family, social and school functioning. Studies since 1980 reveal that of currently depressed children, depression and psychosocial dysfunction among their parents are frequent (Beardslee et al., 1983; Costello, 1986; Hammen et al., 1991). Furthermore, longitudinal studies suggest that the remission or continuation of parental depression is concurrently and predictively linked to the severity of children's depression (Billings & Moos, 1985).

Children's academic performance and peer relationships are also negatively impacted by depression. Cantwell and Carlson (1983) suggested that a large percentage of children doing poorly in school, independent of learning disabilities, are suffering from depression. Low motivation, deficits in problem-solving and poor attention, as well as negative self-evaluation impact the depressed child's ability to perform at his or her best in the structured school environment (Kaslow et al., 1983). Depressed children also have difficulty in initiating and maintaining close, supportive peer relationships (Kennedy et al., 1989). Depressed children tend to interact more negatively with their peers and to be rejected and isolated (Altmann & Gotlib, 1988).

Given these disturbing findings, it is imperative that clinicians treating depressed children understand the context in which depression occurs. Intervention which is based upon an understanding of the developmental process of childhood and the child's family, social and academic functioning can best address the needs of depressed children. Future research exploring the outcomes of such treatment would be helpful and welcome.

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